12 Standardized Medigap (Medicare Supplement) Plans

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Medicare supplement plans

Medicare supplements (commonly called Medigap policies) are health insurance policies that provide a way to fill the coverage gaps left by Medicare. There are 12 standardized Medigap plans (Plan A through Plan L). Medigap insurance is always sold as one of these plans.

While Plans A through L differ from one another, each plan conforms to federal standards for that particular plan. In other words, all Plan Bs meet the same standards; all Plan Gs conform to the same standards. No matter which company you buy Plan E from, it will cover all of the same things that any other company's Plan E does. No company offers a "better" or different Plan E.

Therefore, when selling these plans, insurance companies compete based on premiums, service, company reliability, and issues such as waiting periods for pre-existing conditions or guaranteed issue after open enrollment.

Plan A is the most basic policy and offers **"basic benefits"** or **"core benefits."** These include the daily coinsurance you would normally pay for days 61-90 in hospital, the daily coinsurance you would pay during lifetime reserve days 91-150, and the 20 percent under Part B that you would pay for medical services if you relied solely on Medicare.

The basic/core benefits also cover 100 percent of hospital costs for an additional 365 days, once in a lifetime, after Medicare benefits are exhausted.

Each of the nine Medicare Supplement plans (Plans B-J) includes all of the basic/core benefits offered in Plan A, (see comparison chart at end). Plans K - L provide some coverage for basic/core benefits. In addition, Plans B - J provide varying levels of additional coverage.

Each plan addresses a different set of Medicare "gaps," adding benefits such as coverage for medical emergencies in a foreign country, prescription drugs, or preventive medical care. You can choose the best policy for you based on your health, lifestyle and other factors.

Following are standardized definitions of terms or benefits specifically found in Medigap policies:

- **Excess charges:** The difference between the amount Medicare approves and the maximum any physician may legally charge (also called the "limiting charge," which is 15 percent above the Medicare allowable).

- **Foreign travel emergency:** Covers medically necessary emergency care received in a foreign country at 80 percent of the billed charge for Medicare-eligible emergency hospital, doctor and medical care costs. This care must be of the kind that would have been covered in the U.S. by Medicare and must begin during the first 60 days of each trip outside the U.S. This is subject to a $250 deductible and a lifetime maximum of $50,000.

- **At-home recovery:** Extends the Medicare benefit to provide coverage for short-term, at-home assistance with activities of daily living for those recovering from illness, injury or surgery. It pays up to $40 a day or $1,600 annually, but only after at least one visit is paid by Medicare. To qualify, you must first be eligible for Medicare home care.

- **Basic drug benefit:** Coverage for 50 percent of outpatient prescription drug charges after a $250 calendar year deductible, up to a maximum of $1,250 annual benefits, to the extent not covered by Medicare. NOTE: As of January 1, 2006, new Medigap plans will not be sold with a drug benefit. However, pre-2006 plans including a drug benefit will still be honored.

- **Extended drug benefit:** Coverage for 50 percent of outpatient prescription drug charges after a $250 calendar year deductible, to a maximum of $3,000 annual benefits, to the extent not covered by Medicare. **NOTE:** As of January 1, 2006, new Medigap plans will not be sold with a drug benefit included. However, pre-2006 plans including a drug benefit will still be honored.

- **Preventive care benefit:** This coverage pays up to $120 annually for a routine or preventive physical exam or care that is not already covered by Medicare.

A comparison chart of the available medical supplement plans and what they cover.

Basic (Core) Benefits **Part A:** Hospital coinsurance plus coverage for 365 additional days after Medicare benefits end. **Part B:** 20% coinsurance or co-payments for hospital outpatient services. **Part A & B:** First 3 pints of blood per year.	A	B	C	D	E	F	F*	G	H	I	J	J*	K**	L**
	✔	✔	✔	✔	✔	✔		✔	✔		✔	✔	See Notes #	See Notes # #
Additional Benefits	A	B	C			F	F*	G	H			I*	K**	
Skilled nursing facility coinsurance			✔	✔	✔	✔		✔	✔	✔		✔	50%	75%
Part A deductible		✔	✔	✔	✔	✔		✔	✔	✔		✔	50%	75%
Part B deductible			✔			✔						✔		
Part B excess charges						100%		80%		100%		100%		
Foreign travel emergency			✔	✔	✔	✔		✔	✔	✔		✔		
At-home recovery				✔				✔		✔		✔		
Preventive care not covered by Medicare					✔							✔		
Out of pocket annual limit													$4,000***	$2,000***

See your policies outlines of coverage for details about your plan.

NOTES:

* Plans F and J also have high deductible plans as an option. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year deductible ($1790 in 2006). Benefits from high-deductible plans F and J will not begin until out-of-pocket expenses exceed the deductible ($1790 in 2006). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy.

These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

** Plans K and L provide for different cost-sharing for items and services than Plans A – J. **See lists of Plans K and L Basic Benefits (# and # #) on the following page.**

*** These are dollar amounts for 2006. The out-of-pocket annual limit (the maximum total dollar amount you must pay before your plan provides 100 percent coverage), will increase each year for inflation. Once you reach the annual limit, the plan pays 100 percent of the Medicare copayments, coinsurance†, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

† "Coinsurance" is generally the client's share of costs. So, if a plan covers "75 percent coinsurance," this means the plan pays 75 percent of what the client would have paid for the identified service if the client didn't have the Medigap plan.

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Plan K Basic Benefits:

100% of Part A hospitalization coinsurance† plus coverage for 365 days after Medicare benefits end
50% Hospice cost-sharing
50% of Medicare-eligible expenses for the first three pints of blood
50% Part B coinsurance†, except 100% coinsurance† for Part B preventive services

Plan L Basic Benefits:

100% of Part A hospitalization coinsurance† plus coverage for 365 days after Medicare benefits end
75% Hospice cost-sharing
75% of Medicare-eligible expenses for the first three pints of blood
75% Part B coinsurance†, except 100% coinsurance† for Part B preventive services

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